MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT. M

11059

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11059

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7 South Kelly Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Forest Hill
d. STREET ADDRESS: Sandy Hook Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lonza — Middle: Mack — Last: Andrews
4. DATE OF DEATH: Month: August — Day: 14, — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 2,1905
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Alleghany Co., North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ralph T. Andrews
14. MOTHER'S MAIDEN NAME: Ellen Rector
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 215-14-6718
17. INFORMANT (Wife) — Address: RFD #1
Mrs. Lura M. Andrews — Forest Hill, Md.21050

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C. Palmer, M.D.
Address (Street, city, town, or county): S. Main St., Bel Air, Md.21014
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: Aug. 14,1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug.17,1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harf. Co., Md. 21014

24. FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: AUG 16 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11060

CERTIFICATE OF DEATH

11060

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 401 Webb Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Albert	Eugene	Bailey	August	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED ☒	3/16/1925	42 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Bloomingdale Rubber Co.	Marion N C.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lonnie G. Bailey	Minnie Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
WW 2	mb	Mrs Bessie Vanover	401 Webb Lane Havre de Grace Md. 21078

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic coma. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cirrhosis of the liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
5810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Aug 16, 1967, to Aug 19, 1967 that (I) (we) last saw the deceased alive on Aug 19 1967, and that death occurred at 1:50 P.M., from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
[signature]		8/20/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Lajos Mezei	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	8/22/67	Loudon Park Ntl.	Balto. Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Cunningham Dr Havre de Grace Md		AUG 23 1967	[signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11061

CERTIFICATE OF DEATH

11061

1. **PLACE OF DEATH**
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit 07.2
d. STREET ADDRESS: Cokesberry Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: SARA — Middle: Virginia — Last: BEARSch
4. **DATE OF DEATH**: Month: August — Day: 31 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-12-1894
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isac H. STEARN
14. MOTHER'S MAIDEN NAME: Josephine Siler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Harriett Brown, Charlestown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b): Cardiac Asthma — 16 yrs -
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4342

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 27, 1967, to Aug 30, 1967, that (I) (we) last saw the deceased alive on Aug. 30 1967, and that death occurred at 6:25 M, from causes and on the date stated above.

22a. SIGNATURE: Clarence I. Benson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 31-67
22c. PHYSICIAN'S NAME (Type): Clarence I. Benson Md.
22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/4/1967
23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cem.
23d. LOCATION (City or Town) (County) (State): Perryville, Md.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR: SEP 6 1967
25b. REGISTRAR'S SIGNATURE: Edwards Jaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11062

CERTIFICATE OF DEATH

11062

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 67 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
d. STREET ADDRESS: 326 S. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Victor Jackson; Middle; Last: Bevan

4. DATE OF DEATH: Month: August; Day: 3; Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7 1908
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Bevan
14. MOTHER'S MAIDEN NAME: Caroline Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA — INTERVAL BETWEEN ONSET AND DEATH: one day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic hypertensive — 5 yrs
DUE TO
(c): Cardio Vasc. disease — 3 yrs
443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-29, 1967, to 8-3, 1967, that (I) (we) last saw the deceased alive on 8-3 1967, and that death occurred at 7:15 M, from causes and on the date stoted above.

22a. SIGNATURE: Edward J. Simon M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-4-67
22c. PHYSICIAN'S NAME (Type): EDWARD J. SIMON
22d. ADDRESS: HAVRE DE GRACE, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/6/1967
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Havre de Grace Harford Md

24. FUNERAL DIRECTOR: Cunningham & Son ADDRESS: Havre de Grace, Md
25c. REC'D BY REGISTRAR DATE AUG 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11063

CERTIFICATE OF DEATH

11063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 246 N Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

3. NAME OF DECEASED (Type or print): First: Clarence Middle: Leon Last: Bond

4. DATE OF DEATH: Month: August Day: 24 Year: 1967

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1902

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (K.P.)

10b. KIND OF BUSINESS OR INDUSTRY: Aberdeen Proving Gr.

11. BIRTHPLACE (County & State, or foreign country): Churchville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bond

14. MOTHER'S MAIDEN NAME: Eliza Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 217-09-4535

17. INFORMANT: Mrs. Bella B. Bond, Port Deposit, Md. Address 246 Main St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inanition — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of stomach — unknown
DUE TO
(c):

151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/14/67, 19—, to Aug 24, 1967, that (I) (we) last saw the deceased alive on Aug 24 1967, and that death occurred at 7:35 M, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/29/67

22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT

22d. ADDRESS: HAVRE de GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. James A.M.E. Cemtry

23d. LOCATION (City or Town) (County) (State): Granely Hill, Harford, Md.

24. FUNERAL DIRECTOR: Otelia J. Bullock

ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE: AUG 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11064

CERTIFICATE OF DEATH

11064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace, Md.
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXXXXXMd. Jarrettsville
d. STREET ADDRESS: Anderson Lane
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Lulua — Last: Bosley
4. DATE OF DEATH: Month: August — Day: 2 — Year: 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 10-9- 88
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): XX. Street, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Kennedy
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Rigdon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO: 219-16-5592
17. INFORMANT — Address: Sherman M. Bosley Forest Hill, Md. 21050

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden death
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Ch. Arteriosclerotic Cardiac Vascular disease — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post Cholecystectomy Convalescence — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb, 1960, to Aug 2, 1967, that (I) (we) last saw the deceased alive on Aug 1 1967, and that death occurred at 11:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: Willard P. Hudson M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 8/2/67
22c. PHYSICIAN'S NAME (Type): WILLARD P HUDSON
22d. ADDRESS: FOREST HILL Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/5/1967
23c. NAME OF CEMETERY OR CREMATORY: Highland Presbyterian
23d. LOCATION (City or Town) (County) (State): Street, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Charles E. Kurtz Jarrettsville, Md. 21084
25a. REC'D BY REGISTRAR — DATE: AUG 4 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11665 11665

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH a COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MD b COUNTY Harford
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fallston
d STREET ADDRESS RFD 2 Box 96 e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Hubert Middle AARON Last Bullis
4 DATE OF DEATH Month August Day 6 Year 1967

5 SEX M
6 COLOR OR RACE W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH JUNE 12 1906
9 AGE (In years last birthday) 61 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Wilkes Co. N. Caro
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME Lewis Franklin Bullis
14 MOTHER'S MAIDEN NAME Roxie Anne Elledge

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
16 SOCIAL SECURITY NO 237-05-9346
17 INFORMANT Robert V. Bullis Address 3 Dixie Dr Bel Air Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerotic C V Disease
4271
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. EXAMINER ☐
DEPUTY MED. EXAMINER ☒
EXAMINER'S NAME (Type) Gerald E Palmer M.D.
Address (Street, city, town or county) Bel Air Md.
22. DATE SIGNED 8-6-67

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b DATE THEREOF Aug 10, 1967
23c NAME OF CEMETERY OR CREMATORY Mountain Christian
23d LOCATION (City or Town) (County) (State) Joppa, Md. Harford

24 FUNERAL DIRECTOR ADDRESS J.W.T. Archer, Benson Md.
25a REC'D BY REGISTRAR AUG 11 1967
25b REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11065 — 11066

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 8 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 18 Grant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: Connolly

4. DATE OF DEATH: Month: August — Day: 20 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 August 67

9. AGE (In years last birthday) yrs:

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: 8 — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (County & State or foreign country): Havre de Grace, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Robert J. Connolly

14. MOTHER'S MAIDEN NAME: Renalda Szarmack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: N/A

17. INFORMANT — Address: Robert J. Connolly, Same as 2 C&D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Hyaline Membrane disease — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Prematurity
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-19, 1967, to 8-20, 1967, that (I) (we) last saw the deceased alive on 8-20 1967, and that death occurred at 5 A M, from causes and on the date stated above

22a. SIGNATURE: John D. Yun — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 8/20/67

22c. PHYSICIAN'S NAME (Type): JOHN D. YUN

22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 20 Aug. 67

23c. NAME OF CEMETERY OR CREMATORY: Gates of Heaven Cemetery,

23d. LOCATION (City or Town) (County) (State): Lewiston, N.Y.

24. FUNERAL DIRECTOR: Paul G. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: AUG 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11067 11067

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Edgewood~~ Aberdeen
c. LENGTH OF STAY IN 1b: 30 days ~~45 years~~
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: 308 Oak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: Sarah — Last: Fisher
4. DATE OF DEATH: Month: August — Day: 8 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 4, 1907
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Housewife~~ Retired Hostess
10b. KIND OF BUSINESS OR INDUSTRY: Officers Club
11. BIRTHPLACE (County & State, or foreign country): Grassy Creek, N. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Buchanan
14. MOTHER'S MAIDEN NAME: Luy Creassie

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-18-3004
17. INFORMANT — Address: Mr Joseph D Fisher 308 Oak St Edgewood Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, pancreas; metastasis, to portal vein,
DUE TO: liver, ? Spleen
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hepatic vein and pelvic vein thrombosis, recent
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Mark J. Epstein MD — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): MARK J. EPSTEIN, CPT, MC
22d ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Aug. 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial Cemetery
23d LOCATION (City or Town) (County) (State): Abingdon Harford Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. REC'D BY REGISTRAR — DATE: AUG 11 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11068 item #23D G392, 8/25/67 1a

CERTIFICATE OF DEATH

11068

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: ~~Baltimore~~ HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kingsville-rural c. LENGTH OF STAY IN 1b: 10yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2800 Jeruselem Road	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: ~~Baltimore~~ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kingsville Md. 21087 rural d. STREET ADDRESS: 2800 Jeruselem Road Kingsville e. IS RESIDENCE ON A FARM? YES ☒ NO ☐
3. NAME OF DECEASED (Type or print): First Hubert Middle W. Last Gaddis	4. DATE OF DEATH: Month Aug Day 1 Year 19 67
5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: 1-24-1905 9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 10b. KIND OF BUSINESS OR INDUSTRY: Selfemployed 11. BIRTHPLACE (County & State, or foreign country): Georgia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Walter Gaddi's 14. MOTHER'S MAIDEN NAME: Laura Hammontree	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 217-03-7496 17. INFORMANT Address: Mr William H. Gaddi's 2800 Jeruselem Road	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MULTIPLE PULMONARY INFARCTS	2 wks
DUE TO (b)	METASTATIC CARCINOMA	
DUE TO (c)	CARCINOMA of URINARY BLADDER Grade III	6-8 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JAN 16, 19 67, to Aug 1, 1967, that (I) (we) last saw the deceased alive on Aug 1 1967, and that death occurred at 9.30 PM, from causes and on the date stated above.

22a. SIGNATURE: Theodore E. Evans M.D ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED: Aug 2 1967

22c. PHYSICIAN'S NAME (Type) THEODORE E. EVANS MD 22d. ADDRESS 9660 BELAIR Rd BALTo 36 Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-5-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Christian Cemetery	23d. LOCATION (City or Town) Baltimore	(County) Co. (State) Md.
24. FUNERAL DIRECTOR Lasseter Funeral Home	ADDRESS 7401 Belair Rd	25a. REC'D BY REGISTRAR DATE AUG 7 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11069 11069

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 15 Hanover
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence Middle: May Last: Grimes

4. DATE OF DEATH: Month: August Day: 1 Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-16-1900

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (County & State or foreign country): Harford County, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Jones

14. MOTHER'S MAIDEN NAME: Harriett Preston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-22-6730

17. INFORMANT: Mrs. Idella Burt Address: 48 Conway St. Aberdeen, Md. 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cong. heart failure decomp.
DUE TO
(c): Diabetes mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7-17, 1967 to 8-1, 1967 that (I) (we) last saw the deceased alive on 8-1 1967 and that death occurred at 2:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: Berkley Cemetery Inc.

23d. LOCATION (City or Town) (County) (State): Darlington, Harford Co. Md.

24. FUNERAL DIRECTOR: Stella J. Bullock, Havre de Grace Md. ADDRESS 21078

25a. REC'D BY REGISTRAR DATE AUG 4 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11070 11070

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M) OC I 3

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whiteford Rural
   c. LENGTH OF STAY IN 1b: 35 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whiteford, Rural
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Olive — Middle: G. — Last: Harrison

4. DATE OF DEATH: Month: August — Day: 8 — Year: 1967

5. SEX: F

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 25,1909

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Perry Hall, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Schroeder

14. MOTHER'S MAIDEN NAME: Rose Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO: --------

17. INFORMANT — Address: Leslie G. Harrison Whiteford, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY
   IMMEDIATE CAUSE (a): Carcinomatosis. — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   (b): Primary in Breast
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   1 10X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967, to Aug. 8, 1967, that (I) (we) last saw the deceased alive on Aug. 4, 1967, and that death occurred at 6:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Norman H. Gemmill — M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 8/10/67

22c. PHYSICIAN'S NAME (Type): Norman H. Gemmill

22d. ADDRESS: Stewartstown, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: Aug.12, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial

23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Md.

24. FUNERAL DIRECTOR — ADDRESS: John H. Harkins — Delta, Penna.

25a. REC'D BY REGISTRAR — DATE: AUG 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11071

CERTIFICATE OF DEATH

11071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH** — a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
   c. LENGTH OF STAY IN 1b: 6 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: HARFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
   d. STREET ADDRESS: 317 Alliance St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Austin — Middle: HARVEY — Last: LOWE

4. **DATE OF DEATH**: Month: August — Day: 7 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 4 1904

9. AGE (In years last birthday): 62 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED C.P.W.A.

11. BIRTHPLACE (County & State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: REASON LOWE

14. MOTHER'S MAIDEN NAME: Joy CRAIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-32-6788

17. **INFORMANT**: NELLIE R. LOWE, 317 ALLIANCE ST HAVRE DE GRACE MD.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c).)
   PART I. DEATH WAS CAUSED BY.
   IMMEDIATE CAUSE (a): Massive Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
   DUE TO (b): A. S. C. V. D. — years
   DUE TO (c): Emphysema & Senile Bronchitis — years
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   4221

   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Large gastric ulcer penetrating on to pancreas

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 22, 19 67 to Aug 2, 19 67 that (I) (we) last saw the deceased alive on Aug. 7 1967, and that death occurred at 5:05 A.M. from causes and on the date stated above.

22a. SIGNATURE: Charles J. Foley Jr. M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CHARLES J. FOLEY JR.

22d. ADDRESS: HAVRE DE GRACE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 9 1967

23c. NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL GARDENS

23d. LOCATION (City or Town) (County) (State): HARFORD Co., MD.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: AUG 9 1967

25b. REGISTRAR'S SIGNATURE: Jeanne Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G392 9/1767 ph

11072

CERTIFICATE OF DEATH

11672

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norrisville
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Amoss Mill road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norrisville
d. STREET ADDRESS: Amoss Mill road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES Middle E. Last MAGNESS SR.

4. DATE OF DEATH: Month Aug Day 27 Year 1967

5 SEX: M

6 COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: July 14 1883

9 AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min ____

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Steven Magness

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-01-6909

17. INFORMANT Address: Family Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Congestive Heart Failure

DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 19 67 to 27 August, 1967, that (I) (we) last saw the deceased alive on 24 August 19 67, and that death occurred at 5:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: Reginald B. Hummel — M.D. — ATTENDING PHYS [ ] MED DIRECTOR [X] STAFF PHYS [ ]

22b. DATE SIGNED: 28 August 1967

22c PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8-30-67

23c. NAME OF CEMETERY OR CREMATORY: Moreland Menorial Pk.

23d. LOCATION (City or Town) (County) (State): Baltimore Co. Md.

24. FUNERAL DIRECTOR ADDRESS: C.F.EVANS & SON 8802 Harford road

25a REC'D BY REGISTRAR DATE: AUG 30 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11073 — 11073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 60 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital
d. STREET ADDRESS: 314 Lafayette St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — 12-1

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: Ethel — Last: McFarland
4. DATE OF DEATH: Month: August — Day: 24 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-15-85
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Riley
14. MOTHER'S MAIDEN NAME: Mollie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 220-26-0561-A
17. INFORMANT: Mrs. Georgia Manning — Address: 417 Wyn Mar Aberdeen Md. 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Fracture R. femur — INTERVAL BETWEEN ONSET AND DEATH
4040
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell at home
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 8-18-1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.): Home
20f. (City or town) (County) (State): Havre de Grace Harford Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald e Palmer M.D
EXAMINER'S NAME (Type): Gerald e Palmer MD
CHIEF MEDICAL EXAMINER ☐ Bel Air Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 8-25-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: AUG 27 1967
23c. NAME OF CEMETERY OR CREMATORY: Rileyville Cem.
23d. LOCATION (City or Town) (County) (State): Page Co. VA.

24. FUNERAL DIRECTOR: K. Madison Mitchell, Havre de Grace — ADDRESS: M.D.
25a. RECD BY REGISTRAR / DATE: AUG 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11074

CERTIFICATE OF DEATH

11074

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 214 Parke Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Charles — Last: Minnick
4. DATE OF DEATH: Month: 8 — Day: 20 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9 October 1884
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Opwrator (Ret)
10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11 BIRTHPLACE (County & State, or foreign country): Harford County, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Minnick
14 MOTHER'S MAIDEN NAME: Sarah Hoy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 220-48-7551
17. INFORMANT Address: Wife--Same as 2 C & D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
(b): Myocardial infarction — 1 day.
DUE TO
(c): Gastric ulcer
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/13, 1967 to 8/20, 1967 that (I) (we) last saw the deceased alive on 8/20 1967, and that death occurred at 5:45 P.M. from causes and on the date stated above

22a SIGNATURE: Irvin L. Wachsman M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 8/20/67
22c. PHYSICIAN'S NAME (Type): Irvin L. Wachsman, M.D.
22d. ADDRESS: Havre de Grace, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 23 Aug 67
23c NAME OF CEMETERY OR CREMATORY: Lorraine Park Mausoleum,
23d LOCATION (City or Town) (County) (State): Baltimore, Md.
24 FUNERAL DIRECTOR: Melvin MacConnell Sr.
ADDRESS: Parring Funeral Home, Aberdeen, Maryland
25a RECD BY REGISTRAR DATE AUG 23 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11075 11075

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Darlington
   c. LENGTH OF STAY IN 1b: 63 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Route #1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Darlington
   d. STREET ADDRESS: U.S. Route #1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle MILES — Last MURPHY

4. DATE OF DEATH: Month August — Day 13, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 6, 1903

9. AGE (In years last birthday): 63 Yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (County & State, or foreign country): Darlington, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Murphy

14. MOTHER'S MAIDEN NAME: Esther Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 220-03-9476

17. INFORMANT — Address: Mrs. James M. Murphy, Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/1, 19 67, to 8/13, 19 67, that (I) (we) last saw the deceased alive on 8/13 19 67, and that death occurred at 12:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 14, 1967

22c. PHYSICIAN'S NAME (Type): Dr. Dudley Phillips M.D.

22d. ADDRESS: Darlington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Darlington, ...

23d. LOCATION (City or Town) (County) (State): Darlington, Md.

24. FUNERAL DIRECTOR: John H. Hartline

ADDRESS: Delta, Pa.

25a. REC'D BY REGISTRAR DATE: AUG 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11076

CERTIFICATE OF DEATH

11076

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pylesville
c. LENGTH OF STAY IN 1b: Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pylesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle THOMAS — Last NEAL
4. DATE OF DEATH: Month August — Day 1, — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5/21/1888
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Neal
14. MOTHER'S MAIDEN NAME: Hannah Fletcher
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 212-26-5004
17. INFORMANT — Address: Mrs. E.M.Neal, Pylesville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Coronary insufficiency sclr.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO (c): myo condition, hypertension,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 7, 19 67 to Aug. 1, 19 67 that (I) (we) last saw the deceased alive on July 29 19 67, and that death occurred at 11A M, from causes and on the date stated above.

22a. SIGNATURE: Norman H. Gemmill — M.D. ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 8/2/67
22c. PHYSICIAN'S NAME (Type): Norman H. Gemmill
22d. ADDRESS: Stewartstown, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/4/67
23c. NAME OF CEMETERY OR CREMATORY: McKendree Meth. Cem.
23d. LOCATION (City or Town) (County) (State): Airville, York Co., Pa.
24. FUNERAL DIRECTOR: Kenneth W. Osburn — ADDRESS: Stewartstown, Pa.
25a. REC'D BY REGISTRAR — DATE: AUG 4 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingst

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

11077

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c LENGTH OF STAY IN fb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 64 Laurel Brook Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
d STREET ADDRESS: Box 64 Laurel Brook Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BORDEN Middle B. Last PARRISH
4. DATE OF DEATH: Month August Day 19 Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Feb 21 1936
9 AGE (In years last birthday): 31 yrs
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinest
10b KIND OF BUSINESS OR INDUSTRY: Koppers Co
11 BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Williamson L. Parrish
14. MOTHER'S MAIDEN NAME: Vernie Barricks
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: Family Records — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or Town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: O B Fisher M D
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town or county)
22. DATE SIGNED: August 20, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8/23/67
23c NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park
23d LOCATION (City or Town) (County) (State): Balto Md.

24 FUNERAL DIRECTOR ADDRESS: C.F.EVANS & SON 8802 Harford Rd.
25a REC'D BY REGISTRAR DATE AUG 23 1967
25b REGISTRAR'S SIGNATURE: J Charles Jones

Item 18 Film 393,10-20- MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11078 11078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE: Maryland — b COUNTY: Cecil
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c LENGTH OF STAY IN 1b: 2 hrs.	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora — Rural
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital	d STREET ADDRESS: Colora, Maryland — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First HAROLD — Middle GLENN — Last PATRICK	4. DATE OF DEATH: Month August — Day — Year 19 67
5 SEX: Male — 6 COLOR OR RACE: White — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: Jan. 19, 1928 — 9 AGE (In years last birthday): 39 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor — 10b KIND OF BUSINESS OR INDUSTRY: State Roads — 11 BIRTHPLACE (State or foreign country): North Carolina — 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME: William G. Patrick — 14 MOTHER'S MAIDEN NAME: Florence Pennington	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16 SOCIAL SECURITY NO: 213-26-7607 — 17 INFORMANT: Mrs. Harold Patrick — Address: Colora Md.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ~~Pneumonia~~ Pancreatic abscess and peritonitis — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — (b) Acute or chronic pancreatitis — DUE TO — (c)
577.0
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19 — 20d INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e PLACE OF INJURY (Home farm factory, street, office bldg, etc.) — 20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Russell S. Fisher, M.D. — M.D.
CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED: August 20, 19 67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: 8-22-1967	23c NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.	23d LOCATION (City or Town) (County) (State): Colora Cecil Md.	
24. FUNERAL DIRECTOR: Vernon M. Mullen	ADDRESS: Rising Sun, Md.	25a. REC'D BY REGISTRAR DATE: AUG 22 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11079

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace Md
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Concord Cove Apts 14 D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Josephine — Middle: Burns — Last: Peterson
4 DATE OF DEATH: Month: 8 — Day: 8 — Year: 67 — 19
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Aug. 11-1906
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: —
11 BIRTHPLACE (State or foreign country): Tennessee
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service: No
16. SOCIAL SECURITY NO: Unk
17 INFORMANT: R. Douglas Peterson — Address: Concord Cove Apts 14D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐ [signature]
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): [illegible]
Address (Street, city, town or county)
22. DATE SIGNED

23a BURIAL CREMATION REMOVAL (Specify): —
23b DATE THEREOF: 8/12/67
23c NAME OF CEMETERY OR CREMATORY: Hillandale Park
23d LOCATION (City or Town) (County) (State): Knoxville Tenn

24 FUNERAL DIRECTOR: [illegible] — ADDRESS: [illegible] Havre de Grace Md
25a RECD BY REGISTRAR DATE: AUG 10 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11080 — **CERTIFICATE OF DEATH** — 11080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution. Residence before admission) a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill, Md.
e. STREET ADDRESS: (Box 372) Ady Road
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Harry Middle: Mitchell Last: Price

4. **DATE OF DEATH**: Month: August Day: 14 Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 14, 1914
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State or foreign country): Baltimore Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George E. Price
14. MOTHER'S MAIDEN NAME: Mary B. Tawney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO —
16. SOCIAL SECURITY NO: 212-12-5940
17. INFORMANT (Name): Mrs. Gertrude M. Price Address: R.F.D., Box 372 Forest Hill, Md. 21050

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Rupture thoracic aortic aneurysm (dissecting) — INTERVAL BETWEEN ONSET AND DEATH: 8 to 10 hours
DUE TO (b): ASCVD — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o'm. a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 14, 1967, to Aug 14, 1967, that (I) (we) last saw the deceased alive on August 14 1967, and that death occurred at 10:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Carl Grigoleit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8/14/67
22c. PHYSICIAN'S NAME (Type): A. W. GRIGOLEIT — 22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: August 17, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens — 23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
Joseph William Foster

25a. REC'D BY REGISTRAR DATE: AUG 16 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Part 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11081 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 11081

1 PLACE OF DEATH
a COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Joppa
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Old Joppa Road

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE: Md. — b COUNTY: Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d STREET ADDRESS: 2511 Old Joppa Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Gordon — Middle: Elliott — Last: Purdum
4 DATE OF DEATH: Month: August — Day: 9 — Year: 1967

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 11-19-47
9 AGE (In years last birthday): 19 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Joppa Sand & Gravel
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Joppa Md
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Raymond G. Purdum Sr
14 MOTHER'S MAIDEN NAME: Mildred Regler
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOC. A. SECURITY NO: 218-46-2265
17 INFORMANT: Mrs Mildred Purdum — Address: Joppa Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Fracture Cervicle Vertebra — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Hanged Self
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: August 8 or 9 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): woods
20f (City or town) (County) (State): Joppa Harford Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C Palmer M.D
Address (Street, city, town or county):
22. DATE SIGNED: 8-9-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: August 10, 1967
23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial
23d LOCATION (City or Town) (County) (State): Bel Air Harford Md

24 FUNERAL DIRECTOR: W. Harold Archer — ADDRESS: Benson Md

25a RECD BY REGISTRAR DATE: AUG 11 1967
25b REGISTRAR'S SIGNATURE: Charles Yingling

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11082 11082

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 733 Ontario, St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Alexander — Last: Richardson
4. DATE OF DEATH: Month: 8 — Day: 14 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 8, 1880
9. AGE (In years on last birthday): 87 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: City Hall Retired
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Richardson
14. MOTHER'S MAIDEN NAME: Mary Funk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 218-03-7446
17. INFORMANT: Wm. Kemp Richardson — Address: 2027 Rodman St Hollywood, Fla. 33020

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arterio sclerosis — 10 yrs
DUE TO
(c): Chronic myocarditis — 5 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 14, 1967, to August 14, 1967, that (I) (we) last saw the deceased alive on August 14 1967, and that death occurred at 6:55 P M, from causes and on the date stated above.

22a. SIGNATURE: E J Simon — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/14/67
22c. PHYSICIAN'S NAME (Type): E. J. SIMON
22d. ADDRESS: Home Ave Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 17 1967
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cem.
23d. LOCATION (City or Town) (County) (State): Havre de Grace, Harford, Md.

24. FUNERAL DIRECTOR — ADDRESS: R. Madison Mitchell, Havre de Grace Md.
25a. RECD BY REGISTRAR: DATE AUG 17 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11083 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 11083

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Street~~ Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Railford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: RD 2 Box 308A
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Timothy — Last: Rinehold

4. DATE OF DEATH: Month: August — Day: 18 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 6-8-53

9. AGE (In years last birthday): 14 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Havre de Grace, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael P. Rinehold

14. MOTHER'S MAIDEN NAME: Cordelia Workman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mrs. Michael Rinehold, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Tractor upset on him

20c. TIME OF INJURY Month, Day, Year: 11:50 AM 8-18 1967

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.): Farm Road

20f. (City or town) Street (County) Hd. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D. M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER [ ] Bel Air - Md.
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):

22 DATE SIGNED: 8-18-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Aug. 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's
23d. LOCATION (City or Town) (County) (State): Pylesville, Md.

24. FUNERAL DIRECTOR: John Ed. Harkins — ADDRESS: Delta, Pa.

25a. RECD BY REGISTRAR DATE: AUG 22 1967
25b. REGISTRAR'S SIGNATURE: Juliana Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the (first) director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in on event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11084 11084

CERTIFICATE OF DEATH

1 **PLACE OF DEATH**
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b: 0
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hosp.

2 **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS 107 Stokes St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First Regina — Middle — Last Rosentreter

4. **DATE OF DEATH**: Month August — Day 3 — Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Oct 16 1906

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State, or foreign country): Washington D.C.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis Fenlon

14. MOTHER'S MAIDEN NAME: unk

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service: No

16 SOCIAL SECURITY NO: unk

17. INFORMANT: Floyd Rosentreter — Address: 107 N. Stokes St Havre de Grace Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Tbr. pulm. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Dehydration, due to diarrhea.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 8/2, 1967, to 8/3, 1967, that (I) (we) last saw the deceased alive on 8/3 1967 and that death occurred at 10:25 A.M., from causes and on the date stated above

22a. SIGNATURE — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF 8/7/67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d LOCATION (City or Town) (County) (State): Havre de Grace Md

24 FUNERAL DIRECTOR — ADDRESS: Cunningham & Son, Havre de Grace, Md

25a. RECD BY REGISTRAR DATE AUG 9 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11085

CERTIFICATE OF DEATH

11085

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hare & Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen 12-1
d. STREET ADDRESS: 316 Baltimore St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Grason — Last: Rowe.
4. DATE OF DEATH: Month: August — Day: 31 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1896
9. AGE (If years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physical Therapist
10b. KIND OF BUSINESS OR INDUSTRY: Vet. Admin.
11. BIRTHPLACE (County & State, or foreign country): Gloucester, Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson C. Rowe (D)
14. MOTHER'S MAIDEN NAME: Augusta Handspaker (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): ~~WW-I~~ Yes WW-I
16. SOCIAL SECURITY NO: 213-40-1674
17. INFORMANT: W.N. Rowe, Newark, Delaware — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pleural effusion & atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Mitral & aortic Valvulitis, — 1 yr.
DUE TO (c): Arteriosclerotic cardiovascular disease — 1 yr.
410x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-13-, 19 67, to 8-31-, 19 67, that (I) (we) last saw the deceased alive on August 31 19 67, and that death occurred at 2:27 P.M., from causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 9-2-67
22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.
22d. ADDRESS: 8 Law Street, Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6 Sep. 67
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Ft. Myer, Virginia

24. FUNERAL DIRECTOR: Webster Mcomber Sr.
ADDRESS: Tarring Funeral Home Aberdeen, Md.
25a. RECD BY REGISTRAR DATE: SEP 6 1967
25b. REGISTRAR'S SIGNATURE: [illegible] judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11086 11686

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Forest Hill
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chestnut Hill Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Forest Hill
d. STREET ADDRESS: Chestnut Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Effie Middle: ---- Last: Shumate
4. DATE OF DEATH: Month: August Day: 1, Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19, 1914
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Mfg. Co.
11. BIRTHPLACE (County & State, or foreign country): Troutdale, Grayson Co., Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Merideth Billings
14. MOTHER'S MAIDEN NAME: Della Caudill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 215-24-9329
17. INFORMANT (Husband) 838-6169 Address: R.F.D., Box #354 Forest Hill, Md. 21050
Mr. George W. Shumate

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer of lung — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO (b): metastases to liver, bone.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-7, 1967, to 8-1, 1967, that (I) (we) last saw the deceased alive on 7-31 1967, and that death occurred at 2P.M. from the causes and on the date stated above.

22a. SIGNATURE: M.D. Hodous M.D.
22b. DATE SIGNED: August 1, 1967
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): F.O. Hodous
22d. ADDRESS: Edgewood, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 4, 1967
23c. NAME OF CEMETERY OR CREMATORY: Sharon Baptist Ch. Cem.
23d. LOCATION (City, town or county) (State): Forest Hill, Harf. Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph William Foster
ADDRESS: W. Broadway & Williams Bel Air, Maryland 21014
25a. REC'D BY REGISTRAR DATE: AUG 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Joseph William Foster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11087 11087

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: RD 2 Craigs Corner Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alden Middle: Robert Last: Silver

4. DATE OF DEATH: Month: August Day: 31 Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARS 1885

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOEL W. SILVER

14. MOTHER'S MAIDEN NAME: MARY IOLA SPENCER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 215-36-8177

17. INFORMANT: Mrs. Ed. Ly. Preston Address: R.D. Havre de Grace Md. 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebro vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
DUE TO (b): Arterio sclerotic Cardio Disease — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 or 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-24, 1967, to 8-31, 1967, that (I) (we) last saw the deceased alive on 8-31 1967, and that death occurred at 11:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Ralph Harley M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 9/1/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rock Run Cem.

23d. LOCATION (City or Town) (County) (State): Harford Co. Md.

24. FUNERAL DIRECTOR: R. Madison Mitchell, Havre de Grace Md.

25a. RECD BY REGISTRAR DATE: SEP 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11088 Item #8 Film #G392 9/5/67 ph 11088

11088

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Rd#3 Box 374 (Tollgate Rd.)
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Avis — Middle: Carrie — Last: Williams
4. DATE OF DEATH: Month: 8 — Day: 28 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: [illegible] 17, 1904
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (County & State, or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Washington Sheets
14. MOTHER'S MAIDEN NAME: Sarah Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 230-22-0019
17. INFORMANT: Husband (838-4263) Mr. Joseph M. Williams — Address: RFD#3, Box#374 Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of the Stomach — INTERVAL BETWEEN ONSET AND DEATH: 10 mos.
DUE TO
(b): with Metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-27, 1967 to 8-28, 1967, that (I) (we) last saw the deceased alive on 8-28 1967, and that death occurred at 6:35 PM, from causes and on the date stated above

22a. SIGNATURE: W. Sadowsky M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 8/28/67
22c. PHYSICIAN'S NAME (Type): W.H. SADOWSKY
22a. ADDRESS: 504 Lewis St. Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 31, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Md. 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a. REC'D BY REGISTRAR: DATE AUG 31 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Joseph William Foster

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11089

CERTIFICATE OF DEATH

11090

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belair
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Convalescent Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3009 Glendale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MARY — Middle: E. — Last: WITTHAUER
4 DATE OF DEATH: Month: August — Day: 19, — Year: 1967.
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Feb. 16, 1886.
9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William White
14. MOTHER'S MAIDEN NAME: Mary Jane Oswald

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: Unk.
17 INFORMANT: Address: Rev. Lawrence H. Jongewaard, Belair, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6-1, 1967 to 8-19, 1967, that (I) (we) last saw the deceased alive on 8-18 1967, and that death occurred at 12:30 P.M. causes and on the date stated above.

22a SIGNATURE: Gerald E Palmer M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Gerald E Palmer M.D.
22d. ADDRESS: Bel Air Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8/22/67.
23c NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS:
25a RECD BY REGISTRAR DATE: AUG 22 1967
25b REGISTRAR'S SIGNATURE:

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

110-0

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21091

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 30 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 200 N. Union Ave.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Hartford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 200 N. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First DR. FRANK — Middle OLAF — Last WOLBERT

4 DATE OF DEATH: Month August — Day 15 — Year 19 67

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: JUNE 12, 1904

9 AGE (In years last birthday): 63 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical DOCTOR

10b KIND OF BUSINESS OR INDUSTRY: Medicine

11 BIRTHPLACE (State or foreign country): PA.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: FRANK MAURICE WOLBERT

14. MOTHER'S MAIDEN NAME: CAROLYN CHAMPNEY BURLINGAME

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 216-46-8796

17. INFORMANT: JOHN N. WOLBERT — Address: 1841 Commonwealth AVE. AUBURNDALE MASS. 02166

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Asphyxia due to strangulation
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Subject was strangled

20c TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 8 15 19 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) Havre de Grace (County) Hart. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Investigation ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: R. H. Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

Address (Street, City, town, or county)

22. DATE SIGNED: August 16, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: Aug 18, 1967

23c NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM.

23d LOCATION (City or Town) HAVRE DE GRACE (County) HARFORD (State) MD

24 FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a RECD BY REGISTRAR DATE: AUG 18 1967

25b REGISTRAR'S SIGNATURE: J. Charles Jones

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) M 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11092

1 PLACE OF DEATH
a COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hyde & Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hosp. Jol

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Md
b. COUNTY: Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d STREET ADDRESS: James Run Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Teresa — Middle: Dawn — Last: Wood
4 DATE OF DEATH: Month: August — Day: 7 — Year: 1967

5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19, 1964
9 AGE (In years last birthday): 3 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b KIND OF BUSINESS OR INDUSTRY: NONE
11 BIRTHPLACE (State or foreign country): Harford Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Robert Wood
14. MOTHER'S MAIDEN NAME: Carol Ann Syke

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT (Father): Mr. James R. Wood — Address: R.F.D. #1, Box # 210-A Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Internal Injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
8254
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto Accident
20c TIME OF INJURY Month, Day, Year: Hour a.m. 6 p.m. 8-7 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f (City or town): Aberdeen (County): Hd (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C. Palmer M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: 8-8-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: August 10, 1967
23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Maryland 21014

24 FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a RECD BY REGISTRAR DATE: AUG 9 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

Joseph William Foster

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11092

CERTIFICATE OF DEATH

11093

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE de GRACE 12.1
d. STREET ADDRESS: R.D. #1 Box 298
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cleveland — Middle JAMES — Last Wright
4. DATE OF DEATH: Month August — Day 1 — Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: AUG. 5, 1910
9. AGE (In years Last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: HEXCEL CORP.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William JAMES Wright
14. MOTHER'S MAIDEN NAME: LAURA Singleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-03-6434
17. INFORMANT: Mrs. Bricie E. WRIGHT Address: HAVRE DE GRACE MD RD.1 Box 298

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Pulmonary Angiopenia
DUE TO (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-21, 1967 to 8-1, 1967, that (I) (we) last saw the deceased alive on 8-1 1967, and that death occurred at 9:34 A.M. from causes and on the date stated above.

22a. SIGNATURE: Frank Wilson — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 8/1/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: AUG. 4, 1967
23c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM
23d. LOCATION (City or Town) (County) (State): HARFORD Co. MD

24. FUNERAL DIRECTOR: R. Madison Mitchell
ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: AUG 4 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11093 Items #8 & 9 Film #G392 8/18/67 ph

CERTIFICATE OF DEATH

11094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: 1205 Hanson Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — Last: Yates

4. DATE OF DEATH: Month: August — Day: 31 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 24, 1905

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Electrical

11. BIRTHPLACE (County & State, or foreign country): Grundy, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Columbus Yates (D)

14. MOTHER'S MAIDEN NAME: Linda Matney (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 227-09-4694

17. INFORMANT: Ronald D. Yates — Address: Edgewood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): A.S.C.V.D. — 3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral vascular insufficiency.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-31, 1967 to 8/31, 1967 that (I) (we) last saw the deceased alive on Aug. 31 1967, and that death occurred at 4:15 P M, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/31/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2 Sep. 67

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens,

23d. LOCATION (City or Town) (County) (State): Aberdeen Md.

24. FUNERAL DIRECTOR: John M. Fanning — ADDRESS: Fanning Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: SEP 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge